Children's Mental Health Waiver
Out of Home Care Status Report

This document should be completed in place of the ISP meeting when child/youth is served in out of home care.

Name of Youth: _____

Last/Current Service Plan Date: _____ Date of Team Meeting: _____

Out of Home Care Facility: _____

Date of Admission: _____

Summary of Out of Home Care Stay To Date

Reason for Admission:

Facility Treatment Goals:

- Is the goal to return the child home as soon as possible reflected in service programming, therapeutic strategies, and planning processes? ☐ Yes ☐ No
- Does the Treatment Plan focus on educating and support the child/family to successfully function within the setting to which the child will be returning? ☐ Yes ☐ No
- Does programming and strategies address underlying behavior problems and target behaviors and symptoms that limit the child's success at home and in their school and community? ☐ Yes ☐ No

Facility Services being Provided:
Include frequency and duration of services provided

Child's Response to Services:

Family Involvement:

- Has the family been involved in treatment and had sufficient support to feel confident in meeting the challenges the child may pose when he/she returns home? ☐ Yes ☐ No
- Has the availability of adequate formal and informal community supports to address the child and family's needs been assessed and identified? ☐ Yes ☐ No

What is the identified target date for discharge? _____

Status of Transition Planning

Transition Goals:

Family Care Team's Plans:
What does the Team need to do to get ready to support the child and family when the child comes home?
What are the Team's plans to address problems that are not fully resolved but will not stop the child from coming home?

Team Members present:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family Care Coordinator: _____ Date: _____

Reviewed by MHSASD_____ Date: _____